SUMMARY OF THE DISCUSSION: II. THE ORGANIZATIONAL ENVIRONMENT AND ETHICAL CONDUCT IN OCCUPATIONAL MEDICINE*

MARVIN LIEBERMAN, J.D., Ph.D.

Executive Secretary
Committee on Medicine in Society
The New York Academy of Medicine
New York, New York

THE audience was divided on the extent to which a conflict exists between the loyalty of the occupational physician and the economic health of the corporation. Some physicians argued that being an advocate for the patient may have a relatively small impact in increasing the costs of doing business but that there may be substantial savings in improved morale and greater productivity on the part of the worker and in an ability to attract a better quality of personnel in the medical department.

Dr. Robert Hilker suggested that the physician has an obligation to tell the unions exactly the same things they tell management; the same information should be available to both parties. Dr. Nicholas Ashford of the Massachusetts Institute of Technology, on the other hand, agrees that there is definitely a conflict of interest between the loyalty of the occupational physician to the corporation and to the employees. He asked whether members of the audience were willing to have their sons and daughters work where they would be perfectly agreeable to let other persons work. There are conflicts between larger firms and small firms, and cost-benefit analysis tends to underestimate certain types of costs to the detriment of the worker.

There was a discussion on the extent to which the occupational physician is responsible for diagnosis and treatment of patients. Dr. Gilbeart H. Collings indicated that, in his judgment, as long as the patient is free to choose he should be permitted to obtain his care from the company physician or from outside physicians. Dr. Hilker agreed, and pointed out

*Presented at a *Conference on Ethical Issues in Occupational Medicine* cosponsored by the New York Academy of Medicine and the National Institute for Occupational Safety and Health and held at the Academy June 21 and 22, 1977.

that in some cases it is preferable for the company physician to assume responsibility for the patient's management. This is particularly true in the treatment of alcoholic patients. Of course, in this situation, since coercion may be involved, the work environment is a better place to handle it.

Dr. Bruce W. Karrh pointed out that in Europe the treating and the company physician have separate responsibilities and the American Medical Association's code of ethics suggests that the occupational physician can treat job-related injuries and emergencies but only in cases where there is no outside physician.

Dr. Bertram Dinman indicated that there are limits to what a physician can do—loyalty to the patient is not necessarily at odds with the loyalty to the company. Loyalty to the patient does not necessarily mean that he has to take an advocate's or adversary role in the patient's interest. The patient expects the physician to speak his language and the physician has an obligation to give his best advice to the patient in language that he can understand but not necessarily in great technical detail.

Mr. Steven Kelman said that in his study of testimony before the promulgation of standards for occupational safety and health he found relatively few occupational physicians defending new standards but that they were much more apt to testify against standards which they opposed. In his judgment this tends to reduce the credibility of the occupational physician.

The response from members of the audience was that the many cases where physicians do not testify indicate support. Dr. Dinman cited specific instances where industrial physicians recommended even tighter standards than those promulgated by the Occupational Safety and Health Act.

Dr. Leon J. Warshaw indicated that there are some dilemmas which make the issue of the loyalty of the occupational physician particularly poignant. Twin brothers with the exact same physical condition find themselves in two different settings. One brother wishes to work no longer and his physician finds that his heart disease causes stress and strain. A recommendation is thus made that the employee is totally disabled and should retire. The other brother wants to continue work and he importunes the physician to have him stay on the job since he can argue that work is therapeutic and he should not be laid off. What does the physician do in this case?

There was some discussion about the experimentation on workers. There is no right to experiment on workers who are there to do a job,

according to Dr. Dinman. The same kind of protocols should apply in the work setting as in the pure research setting. If workers are told what is involved and if it is not inconsistent with what the workers are doing, they usually will cooperate if they know the risks.

Miss E. M. Clutis indicated that one reason nurses get less criticism than physicians in the occupational health arena is that they are willing to give more time to patients. In addition, physicians working in industry not only have an obligation to the employee but also to their staff, especially to inform and support their staff.

Dr. Whorton pointed out that the code could help the physician when he wants to do the right thing, but what is the procedure for follow-up? Dr. Hilker pointed out that any physician may seek help from the Occupational Practice Committee of the Occupational Medical Association. He may not only obtain advice but he can send a complaint in writing.